Community Health Centers: a Key Partner to Achieve Medicaid Expansion

Richard Rieselbach, MD[1], Ted Epperly, MD[2], Eleanor McConnell, PhD, RN[3], Jay Noren, MD, MPH[4], Greg Nycz, BS[5], and Peter Shin, PhD, MPH[6]

[1]University of Wisconsin School of Medicine and Public Health, Madison, WI, USA; [2]Family Medicine Residency of Idaho, University of Washington School of Medicine, Seattle, WA, USA; [3]Geriatric Research, Education and Clinical Center, Department of Veterans Affairs Medical Center, Durham, NC, USA; [4]College of Medicine, University of Illinois, Chicago, IL, USA; [5]Family Health Center of Marshfield, Inc., Marshfield, WI, USA; [6]Health Policy and Management, George Washington University, Washington, DC, USA.

Medicaid expansion is an important feature of the "Affordable Care Act" and also is proposed as a component of some incremental plans for universal healthcare coverage. We describe (1) obstacles encountered with Medicaid coverage, (2) their potential resolution by federally qualified community health centers (CHCs), (3) the current status and limitations of CHCs, and (4) a proposed mega CHC model which could help assure access to care under Medicaid coverage expansion. Proposed development of the mega CHC model involves a three-component system featuring (1) satellite neighborhood outreach clinics, with team care directed by primary care nurse practitioners, (2) a hub central CHC which would closely correspond to the logistics and administration of current CHCs, and (3) a teaching hospital facilitating subspecialty care for CHC patients, with high-quality and cost-effectiveness. We believe that this new model, designated as a mega CHC, will demonstrate that CHCs can achieve their potential as a key partner to insure care under Medicaid expansion.

KEY WORDS: Medicaid; community health centers; expansion.

J Gen Intern Med 34(10):2268–72
DOI: 10.1007/s11606-019-05194-1

INTRODUCTION

We believe that federally qualified community health centers (CHCs) can be a key partner with Medicaid in achieving access to care under Medicaid expansion associated with the "Affordable Care Act" (ACA). Furthermore, as additional Medicaid expansion is considered as part of some incremental plans for universal healthcare coverage, this partnership could assume increasing importance. Nevertheless, we believe that three prominent problems with Medicaid coverage present current obstacles to its expansion, and that these could be addressed by the proposed Medicaid partnership with CHCs (Table 1), if CHCs can be modified to accommodate more Medicaid patients. We describe these current Medicaid access to care obstacles, their resolution by CHCs, the current status and limitations of CHCs, and a proposed mega CHC model to help assure access to care under Medicaid expansion.

Received February 18, 2019
Revised May 31, 2019
Accepted July 8, 2019
Published online July 24, 2019

Obstacles to Achieving the Goals of Medicaid Expansion

First, insurance without access to scarce primary care providers will not result in effective care. This is a problem in federally designated shortage areas, where many Medicaid beneficiaries reside.[1] A second problem for Medicaid eligibles is whether providers will accept Medicaid patients. Recent national data indicate that office-based physicians were less likely to accept new Medicaid patients (68%) than Medicare (90%) or private insurance (91%).[2] The national data for mental health and dentistry is even of greater concern, with psychiatrists accepting new Medicaid patients at a rate of only 36%,[2] and only 37% of dentists participate in Medicaid.[3] Third, the phenomenon of the "churning effect" poses a serious access problem. State-level estimates indicate that for those with incomes up to 138% of poverty, only 56% manage continuous eligibility over a 12-month period. Results for those with marketplace coverage (139–400% of poverty) were only marginally better.[4] CHCs accommodate patients caught in this "churning effect" extremely well since, if these patients receive care at a CHC, temporary lapses in coverage due to these transitions do not impact access to care within the CHC setting. This "churning effect" also occurs because of State paperwork barriers, which caused more than 1.5 million low-income people to lose their Medicaid coverage in 2018.[5] Often, Medicaid coverage can be regained when these barriers are addressed and CHCs are staffed to assist patients in obtaining Medicaid and other forms of coverage. As a reflection of the foregoing, enrollment in Medicaid and the Children's Health Insurance Program (CHIP) decreased dramatically in 2018.[5] Between December 2017 and December 2018, total enrollment in Medicaid and CHIP decreased by about 1.6 million. Of those 1.6 million no longer enrolled, 744,000 were children.[5]

In order to address these potential gaps in Medicaid coverage, we propose that State Medicaid programs should increasingly partner with CHCs to provide Medicaid beneficiaries with

Table 1 Obstacles to Receiving Care with Expansion of Medicaid Coverage Addressed by CHCs

I. Primary care provider shortage in federal designated shortage areas
II. Providers unwilling to care for Medicaid patients
III. Coverage "churning" resulting in uninsured episodes

accessible, integrated, and cost-effective continuity of care. In the USA today, there are more than 1400 CHCs that provide primary care for over 27 million people living in rural and urban medically underserved communities. CHCs are particularly well represented in rural areas. Additionally, CHCs have demonstrated impressive effectiveness in managing substance abuse and social determinants of healthcare, as well as providing invaluable professional educational resources.[6–8]

COMMUNITY HEALTH CENTERS—THEIR CURRENT STATUS AND LIMITATIONS

CHCs represent one of the principal sources of primary care for US Medicaid patients.[9] CHCs were initiated within the Office of Economic Opportunity in 1965, and first began with a handful of neighborhood health centers to boost access to healthcare services for medically vulnerable populations. They now include nearly 1400 health centers serving more than 27 million patients at over 11,000 community sites.[10] The mission of CHCs is to provide affordable care for medically underserved and lower-income populations in urban, suburban, and rural communities. Studies consistently show that CHCs improve the health status of individual patients and the communities where they are located.[6] CHCs accept all patients, regardless of insurance status, ability to pay, or immigration status. Many CHCs deploy interdisciplinary care teams to provide comprehensive services, including dental, vision, behavioral healthcare, and pharmaceutical consultations, and even enabling services such as transportation and translation which are not typically covered by insurance. In 2018, 91% of CHC patients had incomes below 200% of the federal poverty level, 69% were living below the poverty level, and 23% were uninsured.[10]

CHCs rely on a diverse mix of funding to cover their costs, including Medicare, Medicaid, private insurance, and patient payments which are typically based on income-related fees.[1] Other revenue derives from competitively awarded Health Resources and Services Administration (HRSA) grants, other grants, and contracts from State, local, and private sources. In FY 2017, 44% of all CHC revenue came from Medicaid. The second largest source of health center funding comes from federal health center grants, which accounted for 18% of revenue in 2017. These grant funds are primarily used to help underwrite the expansion of CHC services, particularly for those who are uninsured or for non-billable services. The Affordable Care Act initially supported CHCs by providing $11 billion in new mandatory grant funding over 5 years (2010–2015) to increase the number and capacity of CHCs. Recently proposed legislation in the Senate, with strong bipartisan support, mandates 5 years of further continuous funding at $4 billion per year, starting in the next fiscal year. CHC integration of mental health professionals is particularly effective in managing post-traumatic stress disorders and substance abuse problems. Also, excellent dental care is usually available with reduced fees for those with limited income. Thus, CHCs are well suited for outsourced veterans' primary care.[11]

CHCs are ideal for team-based care because of their success implementing innovations in care delivery and experience with global funding. Located in federally designated areas that suffer from serious primary care recruitment and retention problems, many CHCs employ various team-based strategies, such as panel management and integrated clinical care models, to improve access to coordinated care.[12] Nearly all CHCs (99%) have well-developed electronic health records and are a superb setting for interprofessional education. In 2017, 84% were eligible to participate in CMS' Meaningful Use EHR incentive program and 77% were recognized or certified as patient-centered medical homes.[4] Their potential increased benefits in maximizing quality, increasing access, and minimizing cost, if modified as subsequently described, are depicted in Table 2.[6]

Major expansion of CHCs to increase access beyond their current patient capacity of Medicaid patients has great potential. However, CHCs face increasing difficulty in acquiring the necessary primary care provider workforce to meet desired growth. Many CHCs currently are already pushing their limit; that is, many cannot accommodate more patients given the number of primary care providers they employ—even now, before the demand of additional States expanding Medicaid.[6] Greatly expanding their non-physician primary care workforce via neighborhood outreach clinics would enable CHCs to effectively serve substantially more Medicaid recipients.

We believe that innovations developed via the subsequently described mega CHC model projects can serve as a catalyst for the required modification and expansion of most CHCs, especially if the workforce impediment to expansion of CHCs is addressed.

DESIGN OF MEGA CHC MODEL

We describe design of a mega CHC model which we believe will help assure access to care under Medicaid expansion. It consists of three components as follows: (1) satellite neighborhood outreach clinics, with team care directed by primary care nurse practitioners (NPs). We address logistics of proposed collaborative practice, administration, and financial support. (2) The hub CHC designed to closely correspond to the logistics and administration of current large CHCs, and (3) a teaching hospital which would facilitate subspecialty care for CHC patients.

COMPONENT #1—OUTREACH CLINICS

Outreach neighborhood CHC clinics located in underserved urban areas or rural communities are a key component of the mega

Table 2 Potential Increased Benefits of Mega CHCs—Maximizing Quality, Increasing Access, and Lowering Cost

Maximizing quality
• Strong primary care foundation with EHRs
• PCMH team care
• CHC culture encourages informed and engaged patients
• Effective quality assurance and outcomes reporting by MCO as the payment partner
• Evidence-based, coordinated care with emphasis on prevention and management of chronic disease
• Population health techniques provided via NP case managers with community health workers
• Telehealth to connect complex primary care patients to subspecialist without having them drive to subspecialist locations
Increasing access
• Increased CHC clinical capacity, via PC extender effect of team-care providers, with extended evening and weekend hours
• Increased CHC appointment flexibility and communication via team-care personnel
• Geographic location of outreach clinics in underserved areas
• Ensures access for specialist care via AMC and telehealth
• Increased access to home care via availability of PCMH team and telehealth
• Asynchronous access by HIPAA secured e-mails and patient portals
Lowering cost
• After-hours availability reducing ED utilization
• Asynchronous access electronically preventing high-cost patient visits
• Decreased hospital admissions and ED visits for conditions that can be treated in ambulatory care settings
• Decreased hospital and nursing home admissions due to home care
• Decreased hospital readmissions—facilitates transitions in care, an important strategy for reducing preventable readmission
• Decreased laboratory and imaging costs (via appropriate resource utilization)
• Decreased fragmentation of care with effective access to and utilization of consultations with all specialties
• Malpractice liability protection for CHCs under Federal Tort Claims Act
• Reduced cost of CHC pharmaceuticals through the Federal Drug Pricing Program
• Access to clinical pharmacist guidance for complex regimens of medication, thereby reducing drug cost
• Effective chronic disease management and prevention
• Provision of integrated dental and mental health services
Acronyms:
• CHC—community health center
• EHR—electronic health record
• PCMH—patient-centered medical home
• MCO—managed care organization
• NP—nurse practitioner
• PC—primary care
• AMC—academic medical center
• ED—emergency department

CHC. NPs would serve as the primary care professional leading a local neighborhood team in collaborative practice, coordinating care with the hub CHC, via the electronic health record (EHR).[13] In detailing the design of outreach clinics, we describe (a) logistics of proposed collaborative practice, (b) administration, and (c) financial support for the team-care workforce.

A) Logistics of Proposed Collaborative Practice

Developing outreach clinics utilizing a collaborative practice model could enable CHC expansion in spite of a primary care physician shortage, and could facilitate expansion of many of our CHCs to better address social determinants of health and access challenges.

The patient-centered medical home (PCMH) is an approach to team-care delivery that has demonstrated improved patient experience and population health, and reduced cost of care.[14] The evolving PCMH model utilizes team-based care with clinicians and staff working at the top of their scope of practice.[15, 16] The outreach clinic-based patient care model could enhance the PCMH by its extension into neighborhoods and communities where patients live. Compared with the usual visit in a large CHC clinic, team care in these settings could better facilitate many components of care, such as health education, screening, and awareness of social determinants impacting health.[17, 18] This neighborhood approach to comprehensive primary care could be located in urban public housing developments or in small rural community clinics. The EHR of each patient would support care coordination across disciplines and with the hub CHC in that region.

Neighborhood-based primary care providers leading this care team would be NPs, who would work with team-care providers. Physicians in the appropriate primary care specialty within the hub CHC would be available if needed via telehealth, including the EHR, or in-person (Fig. 1). Subspecialty consultation could be facilitated by the hub CHC staff with collaborating subspecialties if necessary (component #3).

EHRs, already a required part of the PCMH, would be the central link between neighborhood clinic providers and the CHC hub primary care Physicians. EHRs, and other digital communication, could serve to convey the perspective of the CHC specialty and subspecialty consultants to the neighborhood-based teams, in response to their consultation request. Electronic support would be essential for communication between team-care members to share data and convey plans for their role in care.

B) Administration of the Neighborhood Outreach Clinic

The outreach clinic team would be led by the NP with advanced competencies in leadership, systems-based practice, and evidence implementation,[19] who would serve as the clinic director, enlisting participation of other members of the team as needed, and assuring the availability of electronic or personal interaction with other CHC providers as needed. The outreach clinic administrator (OCA) would be responsible to the clinic director for administering clinic logistics, including personnel, equipment, and finances. An outreach clinic advisory committee would consist of the OCA, a NP, and a representative from the hub CHC. The advisory committee would establish and administer clinic policy in conjunction with clinic staff and a governing board composed of representatives from the served communities.

C) Financial Support

We project that these neighborhood clinics will demonstrate a new venue for expanding team care. This innovation will require a funding mechanism which is flexible and supports team members according to their participation. With a greater emphasis on the social determinants of health,[17] population health, complex medication management, and physical or virtual integration of behavioral and oral health into primary care, neighborhood practices and their hub CHCs would be deploying teams with

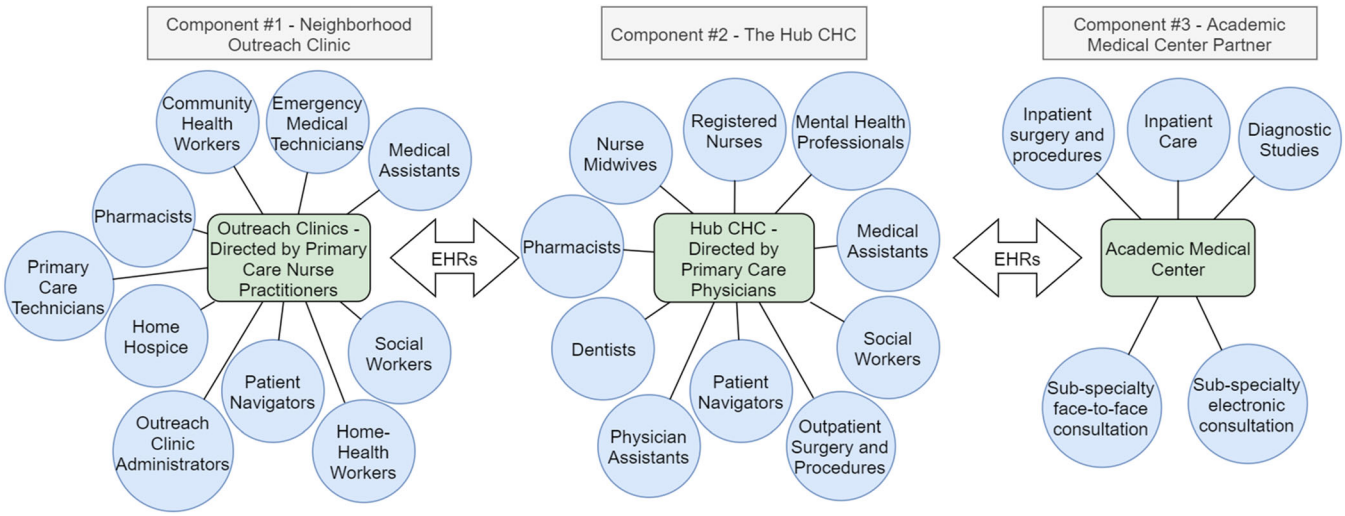

Figure 1 Interaction of the three components and their providers of mega CHCs facilitated by EHRs (electronic health records) and other digital communication.

new members to bring expertise to these complex issues closer to where patients live. This array of health workers might go beyond the "traditional" professions to include patient navigators, community health and home care workers, medical assistants, primary care technicians, social workers, and public health professionals focused upon prevention. They will require a global funding mechanism for support, as subsequently described.

COMPONENT #2—THE HUB CHC

The hub CHC would be designed to closely correspond to the logistics and administration of current CHCs, which has been extensively described.[6] In that setting, team care would be directed by primary care physicians, with team-care collaborators as noted in component #2 of Figure 1, including physician assistants. NPs, directing outreach clinics, would be affiliated with hub primary care physicians.

Because of the diversity of providers, global funding as described for outreach clinics would be required. We view the mega CHC hub as being closely affiliated with a regional academic medical center (teaching hospital) and serving as an excellent clinical campus for a Teaching Health Center Graduate Medical Education program (THCGME).[6]

We believe that a viable THCGME program is crucial for development of the mega CHC. It will be essential for training the increased number of primary care physicians required for growth of the hub CHC component of the mega CHC model. Just as with CHC future funding as previously described, 5-year mandatory funding of the THCGME program is essential and is currently being proposed.

COMPONENT #3—THE ACADEMIC MEDICAL CENTER

We view the academic medical center (AMC) as a key component of the mega CHC. The role of academic medical centers (teaching hospitals) in partnership with CHCs has been well described.[20] This collaboration facilitates subspecialty care for CHC patients with high-quality and cost-effectiveness. Electronic consultation is particularly effective in controlling the cost of subspecialty care.[20, 21]

We envision implementation of CHC/AMC partnerships (CHAMPs) as an important outcome of the mega CHC demonstration. CHAMPs would merge the primary care expertise of CHCs with the medical technology, inpatient care, and subspecialist expertise of AMCs.[20] These partnerships would offer patients ready access to high-quality subspecialty care from the teaching hospital partner who would provide predominantly electronic consults as well as backup personal care when necessary, as well as access to imaging, laboratory tests, and inpatient care. Electronic consultations will be very cost-effective if provided by subspecialty fellowship trainees under supervision of faculty, according to the teaching hospital model.

FUNDING OF THE MEGA CHC

We propose that several States designate one of their well-developed CHCs as the site of an enhanced mega CHC demonstration, which would be supported via a section 1115 waiver in order to enable the anticipated successful mega CHC demonstrations to serve as a catalyst to transform CHCs as described.[22] Providers in components 1 and 2 and component 3 consultants, as well as all other patient care expenses (except for THCGME support by HRSA), would be supported by global payment from a managed care organization (MCO) payment partner of the demonstration, with limited downside risk.[23, 24] The CHCs participating in the demonstration would continue to serve their non-Medicaid patients under current reimbursement mechanisms. The capitated, value-based payment for Medicaid patients, as previously advocated,[23] would be provided by a non-profit MCO, similar to the Hennepin Health Medicaid demonstration project.[24]

LOOKING AHEAD

Currently CHCs serve one in three people in poverty and one in six on Medicaid.[10] Hopefully, the proposed demonstration would provide a model to drive the transformation of CHCs to become an even greater asset to the Medicaid program. Our proposal is dependent upon Center for Medicare and Medicaid Services (CMS) support of the mega CHC demonstration as meeting the objectives of State Medicaid innovation. Section 1115 waivers of the Social Security Act via CMS give the Secretary of Health and Human Services authority to approve innovative demonstration projects that are likely to assist in promoting the objectives of the Medicaid program.[22] The purpose of these demonstrations, which give States additional flexibility to design and improve their Medicaid programs, is to demonstrate and evaluate state-specific policy approaches to better serve their Medicaid populations. We believe that the proposed mega CHCs can meet the objectives of State-level Medicaid innovations. Furthermore, experience gained regarding Medicaid global payment would be valuable in future debates regarding State block grants for Medicaid.

If successful, these demonstrations could serve to validate the advantage of a multi-specialty primary care group practice with neighborhood satellite clinics as a means of achieving the CHC expansion necessary to accommodate more Medicaid, as well as uncovered patients. As of now, expansion of CHCs in medically underserved areas, such as rural settings and low-income urban communities, requires training of primary care physicians to fuel this expansion. However, the number of trainees in US medical residency programs will not meet this demand.[6] We have proposed development of NP-led outreach clinics affiliated with the mega CHC, in order to facilitate the necessary CHC expansion, accommodating more Medicaid patients with the features noted in Table 2.

Acknowledgments: *We gratefully acknowledge the efforts of Ms. Grace Compton in preparation of this manuscript.*

Corresponding Author: *Richard Rieselbach, MD; University of Wisconsin School of Medicine and Public Health, Madison, WI, USA (e-mail: rer@medicine.wisc.edu).*

Compliance with Ethical Standards:

Conflict of Interest: *The authors declare that they do not have a conflict of interest.*

REFERENCES

1. **Shin P**. The health care safety net: Community health centers' vital role. National Institute for Health Care Management Foundation Web site. https:// www.nihcm.org/categories/the-health- safety-net-community-health-centers-vital-role. Published July 2016. Accessed July 1, 2019.
2. MACPAC (Medicaid and CHIP Payment and Access Commission, Physician Acceptance of New Medicaid Patients, Analysis of the National Ambulatory Medical Care Survey (NAMCS), January 24, 2019.
3. American Dental Association, Health Policy Institute, Medicaid Fee-For-Service (FFS) Reimbursement and Provider Participation for Dentists and Physicians in Every State. hpi@ada.org.
4. **Sommers BD**, **Graves JA**, **Swartz K**, **Rosenbaum S**. Medicaid and marketplace eligibility changes will occur often in all states; policy options can ease impact. Health Aff (Millwood). 2014;33(4):700–707.
5. **Meyer H**. Faulty state renewal processes blamed for Medicaid coverage declines. Published April 19, 2019. https://www.modernhealthcare.com/government/faulty-state-renewal-processes-blamed-medicaid-coverage-declines. Accessed July 1, 2019.
6. **Rieselbach RE**, **Epperly T**, **Friedman A**, **et al**. A new community health center/academic medicine partnership for Medicaid cost control, powered by the Mega Teaching Health Center. Acad Med. 93(3):406–413, 2018.
7. **Witgert K**. Why Medicaid is the platform best suited for addressing both health care and social needs. Health Affairs Blog. Published September 7, 2017. https://www.healthaffairs.org/do/10.1377/hblog20170907.061853/full/. Accessed July 1, 2019.
8. **Rieselbach RE**, **Crouse BJ**, **Frohna JG**. Teaching primary care in community health centers: Addressing the workforce crisis for the underserved. Ann Intern Med. 2010;152:118–122.
9. **Rosenbaum S.** Chapter 3: Reinventing a classic: Community health centers and the newly insured. In: Hall MA, Rosenbaum S, eds. The Health Care "Safety Net" in a Post-Reform World. New Brunswick, NJ: Rutgers University Press; 2012.
10. America's Health Centers. National Association of Community Health Centers. http://www.nachc.org/wp-content/uploads/2018/08/AmericasHealthCenters_FINAL.pdf. Published August 2018. Accessed July 1, 2019.
11. **Rieselbach RE**, **Epperly T**, **Nycz G et al**. Community Health Centers Could Provide Better Outsourced Primary Care for Veterans. J Gen Intern Med (2019) 34: 150–153. https://doi.org/10.1007/s11606-018-4691-4.
12. **Doherty RB**, **Crowley RA**. Health and public Committee of the American College of physicians. Principles supporting dynamic clinical care teams: an American College of Physicians position paper. Ann Int Med. 2013;159(9):620–6.
13. **Kruse CS**, **Stein A**, **Thomas H**, **Kaur H**. The use of Electronic Health Records to Support Population Health: A Systematic Review of the Literature. J Med Syst. 2018;42(11):214. Published 2018 Sep 29.. https://doi.org/10.1007/s10916-018-1075-6.
14. **Epperly T**. The patient-centred medical home in the USA. J Eval Clin Pract. 2011;17:373–375.
15. **Brom HM**, **Salsberry PJ**, **Graham MC**. Leveraging health care reform to accelerate nurse practitioner full practice authority. J Am Assoc Nurse Pract. 2018;30(3):120–130. doi: https://doi.org/10.1097/JXX.0000000000000023.
16. **Park J**, **Athey E**, **Pericak A**, **Pulcini J**, **Greene J**. To What Extent Are State Scope of Practice Laws Related to Nurse Practitioners' Day-to-Day Practice Autonomy? Med Care Res Rev. 2018;75(1):66–87. doi: https://doi.org/10.1177/1077558716677826.
17. **Daniel H**, **Bornstein SS**, **Kane GC**, for the Health and Public Policy Committee of the American College of Physicians. Addressing Social Determinants to Improve Patient Care and Promote Health Equity: An American College of Physicians Position Paper. Ann Intern Med. 168:577–578. https://doi.org/10.7326/M17-2441.
18. **Yaggy SD**, **Michener JL**, **Yaggy D**, **Champagne MT**, **Silberberg M**, **Lyn M**, **Johnson F**, **Yarnall KS**. Just for us: an academic medical center-community partnership to maintain the health of a frail low-income senior population. Gerontologist. 2006;46:271–276.
19. DNP Essentials: The Essentials of Doctoral Education for Advanced Nursing Practice (2006). American Association of Colleges of Nursing. https://www.aacnnursing.org/DNP/DNP-Essentials. Accessed July 1, 2019.
20. **Rieselbach RE**, **Kellermann AL**. A model health care delivery system for Medicaid. N Engl J Med. 2011;364(26):2476–2478.
21. **Nocon RS**, **Lee SM**, **Sharma R**, **et al**. Health care use and spending for Medicaid enrollees in federally qualified health centers versus other primary care settings. Am J Public Health. 2016;106(11):1981–1989.
22. **Rieselbach RE**, **Epperly T**, **Nycz G**, **Rockey P**. Teaching health centers can meet objectives for state Medicaid innovation. J Grad Med Educ. 2018;10(3):362–366.
23. **Bhatia J**, **Tobey R**, **Hochman M**. Value-Based Payment Models for Community Health Centers: Time to (Cautiously) Take the Plunge? JAMA. 2017;317(22):2275–2276. doi:https://doi.org/10.1001/jama.2017.5174
24. **Sandberg SF**, **Erikson C**, **Owen R**, et al. Hennepin Health: a safety-net accountable care organization for the expanded Medicaid population. Health Aff (Millwood) 2014;33:1975–84.